WYOMING MENTAL HEALTH DIVISION
Children's Mental Health Waiver
Choice of Providers Form

Waiver Services Available

Services available through the Children's Mental Health Waiver have been explained to me.

I understand that I have the ability to make decisions regarding what services will be provided for my child and which providers we will work with while he/she is a waiver participant.

I understand that I have a right to request informal dispute resolution or an Administrative Hearing if not given the choice of services or providers.

Participant Name: _____

Providers Chosen

A list of certified Children's Mental Health Waiver Providers available in my area/region has been shared with me and my questions have been answered. I have chosen to work with the following providers:

Family Care Coordinator: _____ Date: _____

Family Trainer: _____

Child Trainer: _____

Mental Health Professional: _____

School Representative: _____

Other (please specify): _____

Other (please specify): _____

Reviewed with no changes made *(date and initials of signature below)*

Signatures

Signature of applicant/parent/guardian/legally responsible representative	Date (mo/day/yr)

If signature of responsible person, what is the relationship to the applicant?

☐ Parent ☐ Guardian ☐ Grandparent ☐ Family member ☐ Other

Signature of witness *(required if the signature is an "X")*	Date (mo/day/yr)
Signature of Family Care Coordinator	Date (mo/day/yr)